



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF HEALTH STANDARDS AND LICENSURE

APPLICATION FOR APPROVAL AS A NURSING ASSISTANT TRAINING AGENCY

DATE SUBMITTED

☐ NEW APPLICATION ☐ RENEWAL APPLICATION ☐ REVISED APPLICATION

FACILITY/SCHOOL/NAME (PRINT)

TRAINING AGENCY NO.

LIST PREVIOUS FACILITY/SCHOOL NAMES

PHYSICAL ADDRESS (STREET, CITY, STATE, ZIP CODE) PRINT CLEARLY

TELEPHONE

MAILING ADDRESS (STREET, CITY, STATE, ZIP CODE)

FAX NUMBER

ADMINISTRATOR/DIRECTOR (PRINT)

INSTRUCTOR NAME (PRINT)

LICENSE NUMBER

EXAMINER NAME (PRINT)

LICENSE NUMBER

OPERATOR NAME & ADDRESS

PLEASE CHECK THE FOLLOWING IF APPLICABLE:

☐ DA LICENSED/FACILITY BASED

☐ LICENSED FACILITY - M/M

☐ LICENSED FACILITY - NO M/M

☐ DEPARTMENT OF HEALTH LICENSED/EXTENDED CARE WING
OF HOSPITAL

☐ NON-FACILITY BASED

☐ VOCATIONAL-TECHNICAL SCHOOL (PUBLIC)

☐ VOCATIONAL-TECHNICAL SCHOOL (PRIVATE)

☐ JUNIOR COLLEGE

☐ COMMUNITY COLLEGE

CERTIFYING AGENCY NAME

What portions of the course will be conducted at the above address:

☐ 75 hours

☐ Clinical

☐ Final exam

What portions of the course **WILL NOT** be conducted at the above address:

☐ 75 hours

☐ Clinical

☐ Final exam

Where will these portions be conducted?

If 75 hours, 100 hours OJT, or examination are conducted anywhere other than at the above address - you must have a signed agreement with the other party. List those training agencies below.

NAME

ADDRESS

NAME(S) OF CLINICAL SUPERVISOR(S) AND LICENSE NUMBERS

STATE AGENCY

☐ APPROVE 2 YEARS

☐ DISAPPROVE

☐ WITHDRAW APPROVE

COMMENTS:

RETURN FAX TO HEALTH EDUCATION 573-526-7656

ADMINISTRATOR SIGNATURE

DATE